

REQUEST FOR BLANKET DENIAL LETTER

DATE REQUESTED_____ **PROVIDER #**_____

RECIPIENT NAME_____

MEDICAID ID #_____

INSURANCE COMPANY NAME ON FILE_____

PROCEDURE CODES NEEDED:

1. _____

2. _____

3. _____

4. _____

5. _____

CONTACT_____

PHONE NUMBER_____

FAX NUMBER_____

PLEASE FAX ALL REQUESTS TO 406-442-0357